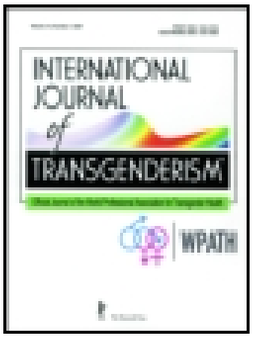

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World Professional Association for Transgender Health Consensus Statement on Considerations of the Role of Distress (Criterion D) in the *DSM* Diagnosis of Gender Identity Disorder

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ABSTRACT. This article explains the report from the work group of WPATH charged to consider whether a diagnosis for gender identity disorder should be included in the revised *DSM*; whether distress is inherent, a result of social stigma, or both; and what the implications of this are for the diagnosis in the revised *DSM*. Suggestions are made to remove gender identity disorder from the next revision of *DSM* and to find a place in the nonmental disorder section of the *ICD*, using the more broadly defined and less stigmatizing term gender dysphoria. Alternative suggestions are also put forward to incorporate distress within Criterion A of a diagnosis of Gender Dysphoria (formerly Gender Identity Disorder) in the revised *DSM*, which will make the condition correspond more closely to its description in the *ICD*.

KEYWORDS. Gender identity disorder, gender dysphoria, transsexual, diagnosis, distress, *DSM*, *ICD*

The World Professional Association for Transgender Health (WPATH) conducted a consensus building process to recommend removal or reform of the diagnosis of Gender Identity Disorder (GID) in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The aim of this process was to discuss and reach an agreement as to whether a diagnosis of GID should be included in the next edition of the *DSM*, currently *DSM-IV-TR* (American Psychiatric Association [APA], 2000) and, if so, what changes would be recommended. Nine work groups were formed, and this is a report from the work group charged to consider one specific criterion of the

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TABLE 1. Diagnostic Criteria for Gender Identity Disorder According to *DSM-IV-TR*

A. Strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
C. Disturbance not concurrent with a physical intersex condition
D. Disturbance causing clinically significant distress or impairment in social, occupational, or other important areas of functioning

current diagnostic category of Gender Identity Disorder: *Is distress (Criterion D) inherent, a result of social stigma (minority stress), or both? What are the implications of the answer for the diagnosis?* Our work group addressed this charge through a 3-month period of discussions via e-mail and a face-to-face consensus meeting at the World Professional Association for Transgender Health (WPATH) Biennial Conference in Oslo, Norway, June 2009.

While the entire WPATH group did not reach consensus as to whether or not a diagnosis for gender identity disorder should be included in the *DSM 5*, our subgroup did reach consensus regarding this issue as well as regarding the role of distress as a diagnostic criterion, and we present our recommendations below.

This article starts with a brief description of the two main international classification systems for mental disorders, followed by a number of considerations with regard to the aforementioned aims of the WPATH consensus process and of our specific subgroup.

INTERNATIONAL CLASSIFICATION OF GENDER IDENTITY DISORDER

The *DSM* is published by the American Psychiatric Association (APA) and provides diagnostic criteria for mental disorders, including Gender Identity Disorder (see Table 1). It is used in the United States and to varying degrees around the world by clinicians, researchers, psychiatric drug regulation agencies, public and private health insurance programs, national health services, pharmaceutical companies and policy makers. The *DSM* has attracted criticism and controversy as well as praise. There have been five revisions since it was first published in 1952 that have gradually included more mental disorders, although some have been removed and are no longer considered as such (e.g., homosexuality and pre-menstrual dysphoric disorder). The last major revision was the fourth edition (APA, 1994), although a text revision was produced 6 years later without any change in diagnostic categories (APA, 2000). The fifth edition of the *DSM* is currently in consultation, planning, and preparation and is scheduled to be published in 2013 (APA, 2009).

The other commonly used guide in mental health is the mental disorders section of the *International Statistical Classification of Diseases and Related Health Problems* (*ICD*). This is published by the World Health Organization (WHO) and is currently in its tenth version (WHO, 1992). The *ICD-10* is the primary reference to mental and behavioral disorders in many European countries as well as in other parts of the world.

Gender identity disorder and transsexualism (diagnoses) appear in both the *DSM-IV* and *ICD-10*, but the terms are used somewhat differently in the two publications. In the *ICD-10*, gender identity disorders include Transsexualism, Dual-Role Transvestism, Gender Identity Disorder of Childhood, Other Gender Identity Disorders, and Gender Identity Disorder, Unspecified. *Transsexualism* is defined in the *ICD-10* as "a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex" (WHO, 1992, p. 215). The *DSM*, on the other hand, does not include Dual-Role Transvestitism, uses *Gender Identity Disorder* as a synonym for *Transsexualism,* and, in line with the mental disorders section of the *ICD-10*, defines *Transvestic Fetishism* as a separate phenomenon, which the *DSM* says can be present in conjunction with *Gender Identity Disorder*.

The coding system used in the *DSM-IV* is designed to correspond with the codes used in the *ICD-10*, although, as described above not all codes match at all times, reflecting

disagreement between the APA and WHO regarding diagnostic categories. This problem is mostly due to the fact that the two publications are—unfortunately—not revised synchronously.

SHOULD A DIAGNOSIS FOR GENDER IDENTITY DISORDER BE INCLUDED IN THE REVISED DSM*?*

Our group reached a consensus that a diagnosis for gender identity disorder should not be included in the revised *DSM*, after taking many complex factors into account. In terms of our discussion, first of all any valid claim as to whether gender identity disorder is a mental or physical illness should start by looking at the evidence to support this claim. The origins and determinants of transgender identity pose unanswered questions of genuine scientific interest. Yet the scientific inquiry they have engendered reveals a long history of distortion by moral and political considerations. Whether transgender identity has a biological basis or not has been related to whether it is an illness or not and, hence, whether or not it should be accepted as a normal variation in the human condition (Meyerowitz, 2002). In the nineteenth century it was attributed first to insanity (e.g., von Krafft-Ebing, 1901) and later to an endocrinological condition (e.g., Benjamin, 1966). In 1980, the term *transsexualism* appeared in the *DSM-III* (APA, 1980) to describe individuals with severe gender dysphoria. Individuals with a gender identity different from that they were assigned at birth were classified as suffering from a mental disorder and, therefore, were formally recognized as having a condition worthy of evaluation and treatment. People who did not have strong identity as male or female, but who nonetheless have gender dysphoria could be diagnosed with Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type, or Gender Identity Disorder Not Otherwise Specified (GID NOS). This development ensured certain legitimacy for treatment. However, it also brought with it (in common with other psychiatric diagnoses) the unwelcome stigma of mental illness. While we strongly believe that having any psychiatric diagnosis is not deserving of stigmatization, we recognize that for the foreseeable future stigmatization is likely to continue, both for Gender Identity Disorder and other diagnoses in the *DSM*.

Whilst there is recent evidence that biological factors are involved in the development of GID (e.g., Chung, De Vries, & Swaab, 2002; Hare et al., 2009; Kruijver, 2004; Zhou et al., 1995), it has been well established that psychological, social, and cultural factors are also involved (e.g., Barrett, 2007; Cohen-Kettenis & Gooren, 1999; Lev, 2004). The continuing political need to distinguish between nature and nurture only serves to obscure the well-accepted scientific notion that psychosexual development involves a biopsychosocial process. It remains difficult, on scientific grounds, to avoid the conclusion that the uniquely human phenomenon that is currently classified as GID in the *DSM* is a consequence of a multifactorial developmental process in which biological factors play a role but in which psychological, social, and cultural factors remain crucially important. The obvious parallel was seen in the political struggle to declassify homosexuality as a mental illness, wherein the functioning of individuals outside of clinical settings became the litmus test of psychopathology. It seems that transpeople, if given appropriate gender-related care, do not have higher rates of psychopathology than the general population (Cole, O'Boyle, Emory, & Meyer, 1997; Haraldsen & Dahl, 2000; Hill, Rozanski, Carfagnini, & Willoughby, 2005). Thus, the difficult moral and political issues at stake must be resolved on grounds other than classifying GID as a mental *illness*, with the attendant notion of dysfunction, especially after any gender-related care has been received.

We are concerned about the continuing stigma of keeping GID in the *DSM*. At the same time, we recognize the need for diagnostic criteria in order to provide appropriate trans-health care. To get around this dilemma, we propose two solutions. One solution would be to include gender dysphoria (instead of GID) as a condition in the nonmental disorder section of the *ICD-11*—a shift in the definition from one section of the publication to another. One could argue that this contradicts our previous reasoning. However, in the currently proposed taxonomies there is little scope for variance or divergence from accepted norms

to be classified in ways other than explicitly, and solely, "disorder," especially where treatment is beneficial. The classification of Gender Identity Disorder in a section of the *ICD* pertaining to biological conditions would afford individuals with gender dysphoria a means of obtaining appropriate (trans) health care. As seen above, there is some evidence for a biological basis for the condition, and many other physical conditions have a social component—pregnancy, for example. While this solution was favored by the group, more work needs to be done to thoroughly explore the implications of making this change. This was not our task.

For the purpose of clarity we use the term *gender dysphoria* to apply to those individuals who experience distress or are likely to and belong at the same time to a diverse group of individuals who cross or transcend culturally defined categories of gender (Bockting, 1999). This latter group includes transsexuals (who feminize or masculinize their body through hormone therapy and/or surgery), cross-dressers (who wear clothing associated with the other sex for varied reasons), drag queens and kings (female and male impersonators) and individuals self-identifying as bi-gender (both man and woman), genderqueer, gender variant, or transgender.

The second possible solution might be to revise the diagnostic criteria of *DSM* to make a diagnosis less stigmatizing and to recognize both that much of the distress experienced by gender dysphoric individuals comes from social stigma rather than simply from the inherent condition of gender variance and that not all distress is meaningful for diagnostic purposes. We recognize that this distress is bidirectional between the individual and the individual's social situation and not easily differentiated. In this paper, we make specific recommendations to eliminate Criterion D of GID in the *DSM* and adjust Criterion A (see Table 1).

IS DISTRESS (CRITERION D) INHERENT, A RESULT OF SOCIAL STIGMA (MINORITY STRESS), OR BOTH?

The *DSM-IV* includes four diagnostic criteria for gender identity disorder (see Table 1). The fourth, Criterion D, states that "[t]he disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."

For transpeople, including transsexual, transgender, or genderqueer individuals, distress is both inherent to gender dysphoria and a product of social stigma. We recognize that exogenous and endogenous distress form a bidirectional interaction wherein they are unable to be easily differentiated. For example, pubertal changes carry with them cultural signifiers of masculinity and femininity attendant to, but somewhat independent of, the physiological and psychological changes themselves. Thus distress may be focused around anatomy, such as the existence or appearance of genitals, or around non-anatomical physiology, such as the sensation of having the wrong hormones coursing through one's body. Additionally, distress with assigned gender status may be experienced independent of anatomical and physiologic concerns, as one moves through day-to-day life being perceived and treated as someone of a sex with which the person does not identify.

Distress may also result from socially and culturally imposed stigma (minority stress; Meyer, 1995). Disclosing one's gender identity or being perceived as gender nonconforming exposes transpeople to the prejudices of others, and to systematic barriers created by policies and practices that do not allow for the existence of trans-identities, trans-bodies, or trans-experiences. This may impact housing, employment, and receipt of health or social services (Bauer et al., 2009), especially sex-segregated services such as women's or men's health clinics, housing shelters, and sexual assault services. Lack of social support and hostility to transpeople impacts family stability, friendships, and work relationships and may contribute to depression.

DISTRESS AS A CRITERION FOR DIAGNOSTIC PURPOSES

It is worth noting that the *DSM-IV* (APA, 1994) classification includes distress as a criterion in numerous conditions, including, Tourette's disorder (307.23), personality change

due to . . . (310.1), amphetamine withdrawal (292.0), caffeine intoxication (305.90), major depressive episode (296), cyclothymic disorder (301.13), sexual dysfunctions (302), paraphilias (302), posttraumatic stress disorder (309.81), acute stress disorder (308.3), generalized anxiety disorder (300.02), undifferentiated somatoform disorder (300.81), conversion disorder (300.11), hypochondriasis (300.7), and dissociative amnesia (300.12). (This list is by no means exhaustive.)

Should distress, independent of whether it is internally derived or comes from external sources such as being discriminated against or stigmatized, be a "core" criterion for diagnosis at all? *Distress* as a term it is a very general use of language, not specifically pathognomonic for GID, and rather open to a wide range of interpretation as to what constitutes marked or clinically significant distress as well as to what constitutes "marked impairment in. . . . " Is it possible to define this criterion more precisely? Distress may be present, but does it clearly define a condition or diagnosis of GID or gender dysphoria?

In contrast to the *DSM-IV*, the *ICD-10* classification (World Health Organization, 1992) does not use Criterion D at all for Transsexualism, Other Gender Identity Disorder, or Gender Identity Disorder, Unspecified, nor for any other mental disorders, which may indicate that this criterion is of little value to "define" the condition or aid in diagnosis. We were unable to find any research papers supporting the argument that Criterion D is necessary to validate a diagnosis of gender dysphoria or gender identity disorder.

We acknowledge that socially and culturally imposed stigma are issues that greatly impact transpeople and may lead to distress for many (cf. Feinberg, 1996; Wilchins, 1997); however, these are nonetheless not relevant to diagnosis. Social distress is not located in the individual, though it may affect the individual. Counseling or psychotherapy, as well as accessing nonpsychologically oriented support, may aid the individual in developing strategies to cope with such socially induced distress. Social factors, however, have the potential to be resolved through social interventions or changes in social norms and acceptance without treating the individual—something that, as gender specialists, we should advocate for alongside our clinical work.

REDEFINING THE ROLE OF DISTRESS AS A CRITERION FOR DIAGNOSIS IN THE DSM 5

If there is to be a diagnosis within the *DSM 5*, then we propose eliminating the current Criterion D and incorporating distress into Criterion A. Our proposed new Criterion A would read as follows:

> Strong and persistent distress with gendered anatomy, physiology, and/or assigned social gender, that is incongruent with persistent core gender identity.

Rationale: "Strong and Persistent Distress . . . "

Distress must be strong, as to exclude those individuals with gender variance for whom it is not disruptive or who can frame an identity around gender resistance or nonconformity without requiring intervention. Distress must be persistent in terms of stability over time to ensure that there will not be postintervention regret and thus harm to the patient.

Rationale: " . . . with Gendered Anatomy, Physiology and/or Assigned Social Gender . . . "

Distress should be tied directly to core issues of dysphoria with respect to anatomy, physiology, or assigned gender. We specifically mention anatomy, as for some people dysphoria manifests itself around genitalia or secondary sex characteristics. We mention physiology because for some people dysphoria manifests itself in everyday experiences of gender incongruous hormones (e.g., feelings of hormones being toxic). We mention social gender (and we recognize that gender is social but retained the modifier to clarify any confusion regarding sex versus gender), as for some people distress may center around assigned gender though

the distress may not necessarily be tied to anatomy.

Rationale: "... That Is Incongruent with Persistent Core Gender Identity"

Identity must be persistent, rather than variable over time. Core identity refers to the quintessence of self that one is intimately aware of.

Note that we specifically excluded references to social or occupational functioning, as transpeople may function well socially or occupationally, but still experience intrapsychic distress. This is a discrete issue from the diagnosis. The fact that this criterion has been in the *DSM* classification for decades, including for other conditions or disorders, is not a valid and persuasive argument to retain it.

CONCLUSION

In short, it is our view that it might well be advantageous to completely reclassify gender dysphoria as something other than a mental disorder. The implication of this would be to remove GID from the next revision of *DSM* and find a place for GID in *ICD* (other than in the Mental Disorders section). We suggest including the more broadly defined and less stigmatizing term *gender dysphoria* in the non-mental disorder section of the *ICD-11*. The main reason for this is to not deny the possibility of access to specialist medical care for any individual with gender dysphoria who would wish to have this.

We wish to point out that the proposed removal of GID from the *DSM 5* in no way obviates the need for mental health professionals to be involved in transpeople's care as ongoing assessment, assistance, screening, support, and advice will still be necessary for people undergoing physical transition, just as these services are with many other conditions.

Inclusion of the condition of gender dysphoria within the non-Mental Disorder section of the *ICD-11* would require significant cooperation and consensus between the APA and the WHO. Realistically this is unlikely to occur in the short term, although it is encouraging that a country such as France has taken a clear stance by declaring that it will no longer classify gender identity disorder as a mental illness ("La transsexualité" 2009). However, we also have to consider that the overall recommendation of the Gender Identity Disorders Subcommittee of the *DSM 5* Task Force may decide otherwise for pragmatic reasons mainly relating to access to health care and health insurance, particularly in the United States and Canada. In this latter scenario, our subgroup would advise discarding Criterion D in its entirety and incorporating distress within Criterion A of a diagnosis of gender dysphoria (formerly Gender Identity Disorder) in the *DSM 5*. This would make the condition as classified in the *DSM 5* correspond more closely to its description according to the *ICD*.

We feel that this move would help to enlighten thinking about gender variance, shifting it from a disease-based model (something went wrong during the individual's development that needs to be corrected) toward an identity-based model of transgender health (not the individual, but stigma associated with gender variance and the associated health disparities are the problem) is to take place (Bockting, 2009).

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